Clinical Section

The Military Aspect of Venereal Disease Control

by Capt. S. L. Williams, R.C.A.M.C., D.V.D.C.O., M.D. No. 10

The effectiveness or non-effectiveness of our Army Venereal Disease Control Programme will depend largely upon the co-operation of civilian doctors throughout Canada. The key to the problem lies in the examination of civil contacts and sources of infection. Each member of the armed forces reporting to his medical officer with a venereal infection has come in contact with some hitherto hidden source of infection in the civil population. To remove this nidus of disease and bring him or her under treatment is largely dependent upon you. This responsibility will require your full co-operation and technical skill. I have, therefore, welcomed this opportunity to discuss with you the military aspects of venereal disease.

The Problem

Venereal disease far outranks any other single communicable disease as a cause of absenteeism in the Canadian Army. The military non-effectiveness that results is difficult to assay. The number of days lost in training time, the disruption of co-ordinated team work, *e.g.*, army tank crews and the physical softening of robust men while in hospital, are just some of the aspects of this phase of the problem.

Consider also the load on the hospitals, the number of beds required and the cost of hospitalization. Other social aspects of the problem include the economic liability of those who subsequently develop syphilitic heart disease or tabo-paresis or gonorrhoeal arthritis. Further and far-reaching effects are to be found in the spread of infection to others, the needless suffering of mothers and children, the tragedy of broken homes and wrecked lives of countless families in our land.

In pre-war days there was well founded evidence that venereal disease was our major health problem. War gives impetus to the spread of venereal infection. The early history of syphilis is stamped with the march of armies through Europe. In this day the exigencies of war has aroused public and governmental action against the evident increase of venereal disease.

Security reasons will not permit statistics but I may say that this district is the fourth highest in Canada, our rate is 15% above the average rate for the Canadian Army in all districts and for the first six months of this year there is a 12% increase over the corresponding period in 1942 in M.D. 10.

The incidence of venereal disease is far greater than mumps, measles, pneumonia and the other common infections. In M.D. 10 there is chance for improvement if we would come down to the Pacific Command level. The record of the United States Army is much lower than ours. They have had a vigorous campaign against venereal disease since their entry into the war.

National Programme

The answer to the challenge is an unified national programme of venereal disease control. The Federal Government has established throughout the Department of National Defence a unified programme of control for the Navy, Army and Air Force. Grants amounting to $175,000 have been made to provincial boards of health and the Federal Division of Venereal Disease Control has been re-established. Every Provincial Board of Health in Canada will intensify its programme of study and action on the problem.

To unify and direct this national effort a true and proven leader was essential. Lt.-Col. D. H. Williams, whom most of you know as a student and graduate of Manitoba Medical School, was appointed director of Canada's answer to the venereal disease threat.

Under administration comes the setting down of policy in regard to venereal disease control, and the institution, development and evaluation of this policy. Personnel must be selected, their duties defined and work supervised. Records had to be set up at National Defence Headquarters and Military District so that reports and personal records could be directed through the proper channels. The collection of statistics had to be unified in method of collection to secure morbidity rate, in order to detect effectiveness or non-effectiveness of our control measures, and to lead us in our epidemiological and research studies.

Of the Preventative Measures I will speak more fully later, but they come under the broad headings of Epidemiology, Education and Early Preventative treatment.

Under Diagnosis and Treatment it is planned to implement the routine blood examination for syphilis of all recruits entering the Army. This has already been established in this military district. All personnel admitted to hospital receive blood examination for syphilis and it is planned to do subsequent examination on all men discharged from the Army and on demobilization at the close of the war.

Physical standards in regard to venereal disease have been set up and now men are rejected only if the heart, nervous system or other visceral effects are present.

The treatment of syphilis and gonorrhoea in the Army has been revised. Syphilitic patients receive a

6 months' course of treatment consisting of 40 injections of Mapharsen and 20 injections of Bismuth following which blood and spinal fluid examinations are carried out.

Ambulatory treatment of gonorrhoea patients with sulfathiozole has been established under supervision of their unit medical officers. Only those who fail to respond to therapy are hospitalized for more intensive chemotherapy or fever treatment.

Liason activity is a very important part of our work. Within the Army itself all branches of the service are used and contact maintained in support of venereal disease control. The Navy and Air Force are pooling their experiences with us through the medium of the Provincial Board of Health with whom we keep in close communication through Dr. K. J. Backman and his staff. Our participation in the work of the Council of Social Agencies of Greater Winnipeg and the educational programme soon to be launched by the Young Men's Section of the Board of Trade comes under this branch.

Epidemiology

The officer commanding a given unit is held responsible for the health of the troops under his command. The medical officer of the unit is his adviser in this regard. He recommends the necessary measures to be taken to avoid epidemics of dysentery, suggests methods of control of respiratory infections and other communicable disease. But the implementation of these measures is the responsibility of the officer commanding. Venereal disease is so closely identified with the morale of the troops that the incidence of gonorrhoea and syphilis among a unit is taken as an index of the efficiency of the officer commanding. A high incidence indicates poor management, a low rate, conditions being equal, speaks well of the unit and its commandant.

Hard training, a full programme of sports, adequate entertainment, and facilities provided to maintain adequate expression of the individual likes and dislikes of the men are all measures which are helpful in reducing the incidence of venereal disease among the troops.

Many of the men coming into the Army are totally ignorant of such diseases as gonorrhoea and syphilis. Certainly the onus is on us if this ignorance is allowed. At our district depot where new recruits are attested the medical officer informs them briefly of the signs, symptoms and the importance of seeking medical attention, the company officers stress the point that to become efficient soldiers and help win the war a soldier must keep himself free of venereal infection and the chaplains approach the man from the moral angle. Sound motion pictures, pamphlets and posters are also used as part of our educational efforts. But the problem of venereal disease control is difficult because, unlike other communicable disease, human behavior and all its inherent defects is involved.

For every infection reported in the armed forces there is a civilian source of infection. Dr. K. J. Backman, Director of Venereal Disease of the Manitoba Board of Health in his article in the *Manitoba Medical Review* of May, 1943, has already drawn your attention to the increase of gonorrhoea and syphilis in the civil population.

Facilitation Process

The community conditions which facilitate the contact of the infected person with the soldier is a very important aspect of control. The professional prostitute and the bawdy house in which she operates is not a serious problem in Manitoba, but there is an area within this military district where recognized houses of prostitution are tolerated. Medical certification of the inmates of these houses is also practiced. The unwary soldier or civilian acts under a false sense of security. In the short time that our new record system has been in force we have already accrued damning evidence against the unwholesome community conditions that exist in this area.

An analysis of 119 reports on sources of infection as supplied by medical officers in this district from February to June of this year indicates that 46% of those reported as the source of infection are in the 15-20-year group and 84% in the 15 to 25-year age group. Twenty-eight per cent named dance halls as the place where the girl was met and 21% were met in cafes. Our problem definitely concerns the younger girls, the "pick-up" on the street, for the trend of our reports shows that for one mentioned as contacted in a bawdy house there are 10 "pick-ups." Only 4 reported payment of a fee to 28 that made no charge. Thus it would appear that promiscuity among young women who are not dependent upon their sex relations for a living but who are out for a "good time" is chiefly responsible.

Further investigation is needed to reveal the social and community condition behind this state of affairs. Has public education been sufficient? Are homes and families disrupted by war or labor demands, responsible? Is there an apathy among parents in their responsibility to their children? Why are young people caught in this emotional whirlpool? Are they ill-prepared to meet the strain of social conditions the war has produced? Are facilities adequate in our cities for the temporary reception and placement of young people coming in from the country in search of employment? Have we paid sufficient attention to the type of entertainment available to the troops when they come into the city on leave? These are only a few of the questions we must answer.

The valuable information which we are receiving in the spread of venereal disease and the social conditions that facilitate the contact is secured from our

Army medical officer. It is the most important single duty the medical officer in the unit performs in the field of venereal disease control. Each soldier reporting to his medical officer with a venereal infection has information regarding the details of his experience. He alone can reveal the facts that will initiate action directed toward the examination and treatment of the source of infection and the community condition that facilitated his exposure. Much depends upon the sympathy and tact of the medical officer and the amount of attention he gives to the interrogation. Both patient and doctor must realize the importance of the information as it concerns the spread of disease to others or the break in the chain of infection that prevents its dissemination.

Time, patience, complete confidence and privacy are essential if complete information is to be secured. The points on which the patient is informed by his medical officer before he is interrogated are:

1. Venereal disease
   (a) Spreads insidiously;
   (b) Contact is a hidden source of disease.
2. Patient's responsibility—
   (a) To refuse permits endless spread of infection to others.
   (b) Information given contributes to future health of others.
3. Confidential nature of information—
   (a) Strictly confidential between medical officer and civilian health department.
4. Identity of the patient—
   (a) Name of patient submitting contact information is not revealed to health department.
5. Investigation of contact—
   (a) Discreet understanding investigation by qualified Health Department personnel;
   (b) Approach based solely on interest in personal health of contact;
   (c) No alleged contact investigation until diagnosis of venereal infection is confirmed.

On the form is filled out the name and the address of the alleged contact or source, and this is the key that unlocks the door to investigation. But even if these are not known a pet name followed by a description of the girl and the occupation or place employed will often enable a good social worker to contact the individual and secure his or her examination and treatment if necessary.

The back of the same form is filled out to seek information on the facilitation process involved in the case in point. Where was the contact met—pick-up on street, in dance hall, or met in a bawdy house. How did the patient meet contact—introduced by friend, pick-up solicited by contact, introduced by pimp, or taxi driver? When was contact met and the time of exposure? Where did the exposure occur—in hotel, rooming house, or bawdy house or park? Was a charge made or payment made to any other person? Had alcohol been used prior to exposure?

The medical officer taking this information forwards this form to the district medical officer in a sealed envelope marked confidential. The Provincial Board of Health in the province in which the source of infection resides is then notified by letter giving full particulars. Kindly sympathetic approach by the social worker will bring the individual concerned under adequate care. Only a few are incorrigible and require institutional care.

In the investigation of the source of infection of gonorrhoea patients treated at the B.C. Board of Health Clinic, seventy per cent supplied contact information; of these 45% were located and examined and 71% of these were positive for gonorrhoea.

Examination of Sources

It is in the clinical examination of patients coming to your office for examination because they have been named as a source of infection that you can be of so much help to us in our venereal disease control programme. In particular the examination of the female patient for gonorrhoea is important. In the first week or two, the profuse discharge, marked inflammation of the meatus and urethral canal, and the ease of demonstrating the gonococcus on the smear leave little room for error. But many are the hazards and pitfalls in the examination and diagnosis of those women who have become asymptomatic carriers or who have passed into a stage of local latency. In such cases the gonococcus is no longer in the surface secretions but deep colonization has taken place in Skene's, Bartholin's and the endocervical glands. Hence repeated examinations are required at which time it is necessary to strip the cord-like induration often found in the region of the urinary meatus, knead Bartholin's gland and remove the cervical mucus plug before taking smears for laboratory study.

Cultures properly taken and controlled would yield further assistance to diagnosis in these cases where strong epidemiological evidence suggests that repeated examination and thorough investigation be carried out before a negative report is submitted to patient or health department.

Summary

In summary attention is directed to the seriousness of venereal disease especially in time of war. Venereal disease not only undermines our national health but also is one of the principal causes of non-effectiveness among armed forces personnel.

It is stated that the answer to the problem is a National Venereal Disease Control Programme, the establishment of which is outlined.

The military aspects of venereal disease control as it applies to M.D. 10 is expressed and our local problems stated.

The epidemiology of venereal disease is discussed and the methods used in the army specifically detailed.

Again may I stress the important contribution you as medical men will make in your professional care and examination of contacts. In your hands lies the responsibility of removing the menace of venereal disease from our men in the forces, our homes and families—Our Canada. Yours is a substantial contribution to the post-war welfare of this country.

Congenital Club Feet and Congenital Dislocation of the Hips

by W. A. Gardner, B.A., M.D.

These are the commoner types of congenital deformity. Club feet are readily recognized and are nearly always of the equino varus type. The important points in the treatment of this condition are to start the correction as soon as it is seen and to continue until the deformity does not tend to relapse. Some correction can be obtained at once and this held with adhesive around the foot, up outer leg and over top of knee. Gradually more correction is obtained with another layer of adhesive laid over the first adhesive, and so on until the foot is completely overcorrected. The co-operation of the mother is most valuable, as she can push the foot around a little farther daily. Great force should never be used in these young infants, as the epiphysis on lower end of tibia may be damaged and stop growth at the lower end of this bone, so that with the fibula continuing to grow the foot will gradually be pushed round reproducing the club foot. Also the top of talus may be flattened so that the ankle loses its rocker movement, and any of the other tarsal bones may become deformed from irregular development. The next point is to persist with the treatment, if necessary, for several years as the tendency is for some of the deformity to recur.

The Denis Browne splint has a popular run now, both gradually to correct the deformity and then to be worn on the boots to keep the child's feet turned out instead of in when it starts to stand and walk. It is a very simple splint and very effective.

If these feet are corrected and kept corrected in infancy, cutting operations will disappear. It is interesting to read that Hippocrates wrote that club feet could be corrected by manipulation and bandaging alone in infants.

Congenital Hips

This condition is very common in some localities and in some races. Thousands of patients have been treated in Bologne, Italy, and in the Bordeaux district in France. It is most important that the dislocation be recognized early and the patient treated when young. Then, and then only, are really good results obtained. If children are not treated until three years or older, the results are very poor, and the older children are perhaps better left alone. Putti in Bologna, who has had thousands of patients, recommended treating his cases when infants and reduced many by just keeping the legs spread apart on a splint. Then he got 95% excellent results. In older patients, three and over, good results are as low as 15%.

The medical profession has an opportunity and a duty to see that this deformity is brought for treatment under two years of age. Any child that has a painless limp should have an X-ray of its hips and any child with club feet should have an X-ray of its pelvis, as deformities are quite often multiple. That is, club feet, club hands and dislocation of one or both hips in the same individual.

There are in the Shrine Hospital five children from one family of nine, three with dislocation of both hips and two with single hips. Only one of these has come in young enough to get a really good result, and it came at sixteen months only because the rest of the patients had come. The oldest girl, thirteen, has not been treated. The second, age seven, has had his hips reduced, and already the head of the femurs is becoming deformed. One girl of three with both hips out promises to do better, and one girl of five with one hip reduced may have a fair result.

What I want to impress on doctors and nurses is their opportunity to do a great service in preventing a child being lame and giving it a good hip, if sent for treatment young. By and large, that is the only time any one gets a high percentage of good results.

Editorials and Association Notes

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Letter from Retiring President

To the Medical Profession of Manitoba—

On the eve of relinquishing my post I wish, through the medium of *The Review,* to express my sincere appreciation of the honor you did me one year ago in electing me to the Presidency of your Association. I would bespeak for my successor, Dr. "Dave" Aikenhead the same loyal support, co-operation and kindness that you so liberally extended to me.

Momentous changes in the status of medical practice are in the offing—changes which will vitally affect every medical practitioner in the land. May I, therefore, as a parting message, urge with all the emphasis at my command, the urgent necessity for each and every member of the profession to fully inform himself on National Contributory Health Insurance by study, thought and discussion.

In addition to this, each of us (if he is to carry his fair share of the load) has a further important duty to perform. That duty is to take out *now* and maintain, active membership in those organizations (the M.M.A. and C.M.A.) which are so jealously protecting his interests. We must present an unanimous, united front *now,* if we are not to risk the possibility of, later on, regretting any present complacency.

Sincerely and gratefully yours,

F. K. Purdie.

Abstracts

Tests for Differentiating Dyspnoea of Heart Failure from that of Emphysema

Desideris Gross (Am. Heart J. 1943 25:335) reports a simple clinical method for differentiating between the dyspnoea of heart failure on the one hand from that of emphysema or asthma on the other. A normal standing subject who blows forcibly after a deep inspiration into a tube connected with a blood-pressure machine can raise the mercury 86 to 170 mm. 10 heart failure patients showed pressures of from 45 to 70 m.m. 10 patients with asthma, emphysema or chronic bronchitis gave normal pressures ranging from 100 to 130 mm. Gross calls this the Expiratory Pressure Test. F.G.A.

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Numb Index Finger

6th C. Disc Syndrome

Semmes and Murphy (J.A.M.A. 1943 121:1209) report 4 cases characterized by severe neck pain radiating to the shoulder, precordium and arm, with numbness in the index finger and to a lesser extent in the middle finger. Muscle spasm made breathing difficult and one patient was cyanosed. All were thought to be coronary attacks at first but this was disproved by investigation. In each case hemilaminectomy disclosed a unilateral herniation of the 6th cervical disc, and removal of the nodule of disc cured the patient. Clinical diagnosis is preferred to lipiodol. F.G.A.

Brandon and District Medical Society Meeting

October 21, 1943

This meeting was held at the Brandon Mental Hospital and was presided over by Dr. H. S. Evans.

Officers for the ensuing year are as follows:

Honorary President—Dr. W. A. Bigelow.
Past President—Dr. H. S. Evans.
President—Dr. C. Thomas.
Vice President—Dr. J. M. Matheson.
Executive—Dr. S. J. S. Pierce, Dr. K. J. Clark, Dr. A. L. Payne.
Sec.-Treasurer—Dr. Stuart Schultz.

The chairman gave a cordial welcome to the ladies and to the members of His Majesty's Forces. An address on "Medicine in the New Order" was given by Dr. F. W. Jackson, Deputy Minister of Health and Public Welfare. This was a clear enunciation of Health Insurance. This was followed by an excellent address on "Common Diseases of the Skin" by Dr. George Brock of Winnipeg. Musical numbers were given by Miss Margaret King, Dr. Roy Martin and Dr. E. S. Bolton.

Obituary

Dr. Daniel Sayre MacKay died in the Winnipeg General Hospital on October 27. Born in 1878 at Reserve Mines, Cape Breton, he was educated at the famed Pictou Academy, then, choosing his father's profession, he graduated from McGill Medical School in 1901. This was followed by post-graduate work in Edinburgh, London and Liverpool under such men as Sir William Mitchell Banks and Dr. Thomas Grimsdale.

Coming to Winnipeg in 1909 he was appointed surgeon to the Children's Hospital. In 1911 he became associate gynaecologist at the Winnipeg General Hospital, in 1913 he received his first university appointment as demonstrator in gynaecology, and rose steadily until in 1926 he was appointed Professor of Obstetrics and Gynaecology and Head of the Department. In 1934 he was elected a foundation fellow of the Royal College of Obstetricians and Gynaecologists. In 1939 he resigned his teaching position and was appointed Professor Emeritus and a member of the Honorary Consulting Staff of the Winnipeg General Hospital.

Thus Minerva claimed him as a devotee but he also worshipped at the shrine of Mars. From the age of fourteen when he joined the 17th Field Battery at Sidney, N.S., his active interest in Canada's military forces never ceased. On the very eve of his death he attended a reunion of the 196th (Western Universities) Battalion which he organized and commanded in the last war. When the Queen's Own Cameron Highlanders of Winnipeg were organized in 1910 he transferred from the Army Medical Corps and in the next year commanded the special company at the coronation of King George V. When the war of 1914-18 broke out he joined the 27th Battalion on its organization, served as second in command in Belgium and France, then in succession commanded the 196th Battalion, the 19th Reserve Battalion and the Young Soldiers' Battalion. The opening of the second great war found Col. MacKay in command of the 7th Infantry Brigade reserve from which he retired in May, 1942.

For a number of years he served with distinction as acting provincial commissioner of the St. John's Ambulance Brigade.

As befitted one sprung from Highland stock Dan MacKay was intensely faithful to his loyalties, positive, forthright and full of generous impulses. John Bunyan would have called him Valiant-for-truth, for he was always quick to defend his principles even against odds. He was filled with the zest of life and had the keenest interest in the welfare of young men, whether among soldiers or students. From the latter he earned the honour of the nickname "Dugout Dan."

His wife, who was chairman of the Billetting Committee of the 1930 Winnipeg meeting of the British Medical Association, predeceased him, but he is survived by his only son, Squadron-Leader W. A. F. MacKay, R.C.A.F., stationed at Gimli, Man.

As teacher, soldier and public citizen, D. S. MacKay left a distinct impress on the life of Western Canada.

Personal Notes and Social News

Dr. and Mrs. Norman I. Corne announce the arrival of a daughter (Susan Roberta) at the Winnipeg General Hospital, September 25th, 1943.

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Major G. D. McTavish was a guest of honor at a dinner and presentation given by officers of M. D. 10 District Depot, Fort Osborne Barracks, on October 1st. On behalf of his former colleagues, he was presented with a desk set.

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Neil Bruce MacLean (R.C.A.M.C.) son of Dr. and Mrs. Neil John MacLean was married Friday, October 1st to Jeanne, a daughter of Dr. and Mrs. Collins of Clanwilliam, Man.

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Dr. C. M. Vanstone, for twenty-one years managing Director of the Wawanesa Mutual Insurance Co., has resigned because of failing health.

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Lord Dawson of Penn was unanimously elected president of the British Medical Association at its annual meeting.

Dr. Paul L'Heureux of St. Boniface was presented with an award in the national health honour roll contest to municipal health officers, at the recent meeting in Toronto, of the Canadian Public Health Association.

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Dr. Allan Douglas Bracken has been appointed to the active army with the rank of Captain.

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Dr. and Mrs. Frank Peavey Cameron have returned to Winnipeg after spending five years in England. For the past three years Dr. Cameron has been working in London with the Ministry of Health as surgeon to the Emergency Services. Dr. and Mrs. Cameron are guests of his parents at 838 Wolseley Avenue.

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The following Manitoba doctors were successful in passing the recent examinations held by the Medical Council of Canada: Dr. Joseph Brunet, St. Jean Baptiste; Dr. F. P. Leckie, and Dr. A. O. Stebnickie, of Winnipeg.

Winnipeg Medical Society

C. M. STRONG—*President*
P. H. MCNULTY—*Vice-President*
MEETINGS
Third Friday, each month

C. B. STEWART — *Past President*

Next Meeting
November 19th

W. F. TISDALE—*Secretary*
H. M. EDMISON—*Treasurer*
MEETINGS
Start exactly at 8:15 p.m.

NOTICE BOARD

For seventeen or more years the Rev. Jack Mathieson has been an evangelising missionary to the Chinese. At our meeting on October 15th he was for two hours an evangelising missionary *for* the Chinese, and I am sure that he converted everyone of a respectably large audience.

He told the story of the battles, sieges, fortunes that he had endured. Like Othello he spake of most disastrous chances, of moving accidents by flood and field, of hair-breadth 'scapes i' the imminent deadly breach, of being taken by the insolent foe and, if not sold to slavery, at least beaten, stripped, insulted and humiliated. It was a sad commentary upon the state of man and his universe to think that such things could be in this 20th century of Christianity, this 60th century of civilization. Verily, in the words of Desdemona, " 'Tis strange, 'tis passing strange, 'Tis pitiful, 'tis wondrous pitiful'."

He told us many things in the 90 minutes that he spoke and we saw much in the 30 minutes of pictures. As we listened, I am sure that many of us were wondering how many times he had knowingly taken his life in his hands and faced not merely death but those diabolical agonies which he had seen endured by others and might well experience in himself. I think we all felt a higher respect for missionaries when we realized what they will do for people with whom they have no links of blood, or kinship, or race, or allegiance, or even of colour.

China is an area so vast, in population so huge, in distance so remote that we cannot appreciate its struggle and its needs. Yet, as Mr. Mathieson reminded us, its very immensity increases its sufferings, its dangers and its wants. He pointed out how pitifully small had been the help sent to it, and how desperately that help was required. Stout hearts and the ability to endure could not make up for the lack of food, guns, planes, tanks and medicines.

There is but one weapon that China has in abundance and for that she is indebted to the Japanese themselves. It is the will to fight on. Mr. Mathieson told us how that weapon had been forged and tempered by treachery, torture, pillage and rape. He told us how cruelty and bestiality beyond belief had hardened the Chinese heart till it would endure all things, except conquest by this enemy. These sufferings and experiences had engendered a disgust and a loathing of such consuming intensity that not even the most subtle propaganda, the most barbarous ferocity, the most lavish promises, could mitigate or crush them in the Chinese breast.

Men hate only what they fear. Great then must be the fear that lies in Japanese hearts, so intense is their hatred. They fear defeat. They fear the universal abhorrence and detestation which they know they have earned and which they dare not endure. They fear revenge and perpetrate crimes so terrible that revenge could never be proportionate or complete.

In this three-ring circus of a world-war, we have given only an occasional and passing glance to the China theatre. From now on, all of us who heard Mr. Mathieson will look upon that stage with deep interest.

Just before Mr. Mathieson's talk, the matter of the Overseas Fund came up. When the treasurer went to his books to see how much money he could give us, he found all the important figures were in red ink which, as you know, is pretty bad. The President asked me how much money we needed and I told him that $800.00 would send two parcels a year to each man and that we would rather have $1,200.00, which would pay for two big and two little parcels or three big ones. In the spirit of helpfulness, I threw in the suggestion that we ask the College of Physicians and Surgeons for $500.00, but Cliff Abbott moved that we ask them for a thousand, which motion was carried. Then it was moved that we ask the M.M.A. for $200.00, which also was carried. Russell Cleave added $5.00 to his cheque for his dues and, on the way out, Tony Gowron gave me $10.00.

Last month I had a word to say about Sicily but, as I did not see the proofs and as the printer had his own

ideas about classical mythology, a few errors appeared in the printed article. I was shocked to read of Orpheus chasing the chaste Arethusa, Orpheus, who loved his wife so well! When she died, did he not follow her to the underworld and nearly persuade Pluto to set her free? No, Mr. Printer, the bad lad who put Arethusa in such a pother was Alpheus, who was a wolf if there ever was one. Also, Mr. Printer, Phalaris roasted his victims, not in a brazen well but in a brazen bull; and the ancient name of Sicily is Trinacrium.

Sicily will be to the fore on Friday, November 26th, when Dr. W. A. Gardner will talk about its medical history. This season the papers to be given at meetings of the Medical History Section will deal with the Medical History of the War Zone. The first paper will have been given by the time this gets into print. We dealt with the Alexandrian School. The others in the series are: January, "Salerno," Dr. Ross Mitchell; February, "Rome," Dr. F. G. Allison; March, "Florence," Prof. A. T. Cameron; April, "Padua and Bologna," Prof. I. McL. Thompson. The meetings are held in the Medical Arts Club Rooms. Dinner at 6:30; Meetings at 7:30. The date, etc., for each will be published in advance. Come if you can. P.S.—I wouldn't be surprised if Dr. Gardner runs into a Franch Canadian in Sicily. J.C.H.

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The November meeting (Nov. 19th) will be in the hands of Dr. Bruce Chown and Dr. H. V. Rice. Dr. Chown will speak on Meningitis and Dr. Rice on the Electroencephalograph. Dr. Rice is a most versatile person. He proves his mechanical genius by manufacturing the machine that he will demonstrate. He is also deeply versed in physiology and profoundly interested in music. Those of you who are familiar with the beginnings of medicine will remember the part played by "Doctor" Pythagoras. He was much intrigued by sounds and harmonies and propounded the idea of "the music of the spheres." And now comes Dr. Rice with an instrument to demonstrate the music of the hemispheres.

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Of the making of questionnaires there is no end and answering them is a weariness unto the flesh. For some time now we have been spared this weariness but once again it threatens us. Concerning the larger of the two recent documents I have nothing to say but the smaller one is illuminating.

It shows how times have changed since those anxious days when unemployment was mounting and our revenues were at their lowest ebb. You will recall how eagerly we then approved the "Relief Plan" and feted those who brought it into being. You will remember how we were privileged to collect twenty-five cents for each hospital visit (ye gods! — two bits!); a dollar and a half for each house visit (provided the visit wasn't declared unnecessary), and a dollar if the patient came to see you—with a slip (no slip—no dice). Then it was the surgeon and not the patient who shuddered at the fee. For thirty-five dollars one could be practically eviscerated—nice for the patient, even if he didn't have to pay but for the surgeon, "Oh, horrible! Most Horrible!" as Hamlet once remarked. And think of the injustices and irregularities against which we fought a losing battle. The obstetrician for removing a large mass of tissue through a small orifice after months of watching was given $10.00. The tonsillectomist for removing two small pieces of tissue through a large orifice in fifteen minutes was given—$10.00. Thus, in the matter of fees, at least, did the City Council make the two ends meet.

But now all this is a thing of the past. No more must we exercise our semi-charity. Gone is idleness with its leisure for introspection. Gone are the aches and discomforts that introspection engenders—all gone as the result of applying that potent therapeutic agent—work. "Work," cried Carlyle, "is the grand cure of all the maladies and miseries that beset mankind." Not of all, perhaps, but of a great many and among them the neuroses of which we saw so many examples a few years ago.

We have said good-bye to the old plan. We have flung away the old crutch with which we limped through the Depression. We are well now, but will our health last? What is brewing in political councils? Health Insurance? We do not know, but we can surmise that it bodes us little good. Let us, then, gather our strength against the day when we shall need it so that it may again be with us even as it was in the days of the "Relief Plan" when we showed that in union there is strength. J.C.H.

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Abstract

Prophylactic Acetylsalicylic Acid in Rheumatic Children after Pharyngitis

Coburn & Moore (J. Pediatrics 1942 21:180) asked rheumatic children to report for throat culture at the onset of a sore throat. 4 to 6 grams acetysalicylic acid daily was then prescribed. In 47 cases where culture showed haemolytic streptococci this therapy was continued for 4 weeks. Where no streptococci were found the salicylates were dropped, and none of these patients had rheumatic relapses. Only one of the 47 treated cases had a relapse over the 2-year period of study. 57 of 139 controls had relapses. F.G.A.

Notice from the Council of the College of Physicians and Surgeons of Manitoba

The Workman's Compensation Board Regulations

The College of Physicians and Surgeons of Manitoba wish to draw to the attention of all practitioners in the Province of Manitoba that it is very important that all necessary reports on compensation cases should be completed in detail and forwarded to the Compensation Board without unnecessary delay. Procrastination in this respect not only works a hardship on the employee as he will receive no compensation until the medical forms are submitted, but jeopardizes the payment of the account of the attending doctor.

All medical accounts should be rendered promptly, as there is an expiration period of six months; after which the Compensation Board is not legally responsible for the payment.

Saskatchewan's Stand on National Contributory Health Insurance

The following submission upon National Contributory Health Insurance in the Province of Saskatchewan is provided by the Committee of the College of Physicians and Surgeons of Saskatchewan. These eight propositions, with suitable comment following each proposition, outline the stand taken by the profession in Saskatchewan upon National Contributory Insurance. It might be noted in proposition No. 8 our professional brethren to the West realize the essential need of a united profession to new Health legislation.

RESOLUTIONS

stating fundamental principles without which no Health Scheme can successfully operate.

1. *Medical Practitioners in His Majesty's Service*:

Whereas a high percentage of Medical Practitioners in Saskatchewan are serving in His Majesty's Forces, and

Whereas these Medical Practitioners are vitally concerned in any Health Scheme which may be established,

Therefore be it Resolved that no Health Scheme be adopted in Saskatchewan until these said Medical Practitioners have been consulted and have expressed their views, and, if necessary, until after the war.

COMMENT:

The *Draft Act* will not likely go into force until these men return.

State Medicine ignores these principles entirely and says Saskatchewan shall put a scheme into force at once, regardless of any group of Doctors.

Our Committee feels that no scheme should be put into force in disregard of the rights of the Doctors in Service.

2. *CORPORATION*:

Resolved that any Health Scheme in Saskatchewan should be undertaken and operated by an independent corporate body, severed from governmental and political influence and control.

COMMENT:

The *Draft Act* under Section 16 proposes (a) A National Council of Health Insurance under the Department of Pensions and National Health, appointed by the Governor General, all subject to the Minister of Health.

(b) Under Section 35 a Provincial Health Insurance Commission again under the Department of Health, appointed by the Lieutenant Governor, all subject to the Minister of Health.

State Medicine says the entire Scheme shall be wholly and completely a Government Scheme, operated by the State.

Our Committee feels that the Scheme should be run by an independent organization subject to Government check-up and inspection.

3. *FINANCES*:

Resolved that any Health Scheme in Saskatchewan must conform with principles of sound Finance and Economics, and must be on a contributory basis.

COMMENT:

The *Draft Act* under Section 26 proposes that industry, the insured, and the Government contribute.

The rates are not worked out, but so far as the insured is concerned, an arbitrary figure of $26.00 per adult over 18 years is suggested in Committee.

State Medicine says the Government pays all costs regardless of what they are, out of taxes.

Our Committee feels that the Scheme should be a contributory one, and that a careful study of actual cost be made before levies are struck and finally that provision be made against extraordinary conditions.

4. *REPRESENTATION*:

Resolved that under any Health Scheme in Saskatchewan the Medical Profession shall be adequately represented on all boards and committees, and no such representation shall be appointed except on the recommendation of the College of Physicians and Surgeons.

COMMENT:

The *Draft Act* proposes a National Health Council, a Provincial Health Insurance Commission, Representative Committees, Regional and Divisional offices and Medical Health Officers.

In general, all appointments are made by the Government after consultation.

Note: Already the *Draft Act* is changed to leave the chairmanship of the Commission open to anyone, not necessarily a Doctor.

State Medicine says all groups shall be represented, but at the pleasure of the Government, who has complete control and appointment.

The Committee feels that the Profession must have *adequate* representation and all Medical appointments

shall be made only on the recommendation of the College of Physicians and Surgeons.

5. *REFEREES*:

Resolved that Referees to supervise and control Medical Service and Work shall consist only of Medical Practitioners appointed on the recommendation of the College of Physicians and Surgeons.

COMMENT:

The *Draft Act* proposes Medical Officers appointed by the Commission, but their function is not stated.

State Medicine says all control shall be under the Government and in these matters trained men be consulted.

Our Committee feels that only Medical men can definitely decide whether and when patient or Doctor is abusing the Scheme by unnecessary Services, demanded or given, and only Medical men can pass judgment on work done or to be done and only Medical men can guard against exploitation or abuses.

6. *PAYMENT FOR SERVICES*:

1. *Resolved* that under any form of Health Scheme in Saskatchewan, the Medical Practitioners receive payment for all services rendered, such payment to be on the basis of a Schedule of Fees so revised that under all the circumstances a fair remuneration is provided for work done.

Provided that where local conditions are such that it makes this method of payment undesirable to the Medical Practitioner involved, he shall have the right to a salary contract arrangement set up by the Council for the College of Physicians and Surgeons and the Health Insurance Commission.

2. *Whereas* under the Capitation System of payment the remuneration has no relation to and is not measured by the actual work done or services rendered.

Therefore be it Resolved that the Capitation System of payment be eliminated entirely from any Health Scheme in Saskatchewan.

COMMENT:

The *Draft Act* by 28 (2) (H) proposes the manner of payment and rates to be set up by arrangement between the Commission and Practitioners.

That arrangement may provide for salary, fee for work done, or capitation, or any combination of them.

State Medicine says the Doctors shall be paid by salaries or capitation, set by the Government, after consulting with the Doctors, but no fee shall be charged for service.

Our Committee feels that capitation is not a fair method of payment and would eliminate it and would adopt the other two methods, in combination where desirable.

7. *Whereas* only Medical Practitioners can properly appreciate and evaluate the work and responsibility involved in Medical Services and Work,

Therefore be it Resolved that under any Health Scheme in Saskatchewan, Medical Accounts be taxed by a Taxing Committee to be appointed by the College of Physicians and Surgeons in co-operation with any appointees by the Health Insurance Commission.

COMMENT:

The *Draft Act* makes no specific provision for this.

State Medicine would control this by a Governmental Board.

Our Committee feels that only Doctors can properly evaluate work, responsibility, risk, and other factors that go into Medical Work.

8. *NEED FOR UNTY*:

Whereas the interests of the public and the Medical Profession demand that certain basic principles be incorporated in any Health Scheme.

And Whereas no group is so distinctly the Custodian and Champion of these principles,

Therefore be it Resolved that every member of the College of Physicians and Surgeons in Saskatchewan pledge himself in writing, to submit to, and abide fully by, any decision of, proposal by, or action on any Health Scheme, undertaken by the College of Physicians and Surgeons, after full discussion in open meeting.

Social Security

Minutes of Proceedings and Evidence No. 13.
Extract taken from Page 374.

Mr. Gershaw: I wonder if our honoured guest would express an opinion on the details of the medical services. For instance, what position will the doctor be in? Will he practise from his own office or from some health centre, and how will he be paid for his services, by fee or salary or on a capitation basis?

Sir William Beveridge: That is a very important question, but it is not actually settled in my report and it is not settled yet. What my report says is this: that medical treatment ought to be paid for on a social insurance basis; that is to say, paid for by contributions put in in advance and not by charge when the treatment is given. That is common sense, because when a man falls ill he is apt to lose his income and this is not a time when he ought to have doctors' bills to pay, he ought to have no charge for treatment. The citizen should pay for his treatment by contributions and by taxation beforehand and not by paying doctors' bills. But that does not settle how the doctor is to be

paid or to be employed. It would be quite consistent with my proposals for a doctor to write out his bill every time he visits a patient and send it to a central office instead of to the patient. It would be quite consistent for the doctor to be paid on the panel system that we have at present in Britain. It would be equally consistent with my plan to have a salaried medical service. But the decision between these possibilities is not made in my plan. I have left it open for further discussion. If you ask me what is going to happen I can only say it is now being discussed between the government and the medical profession. The government has said, "We accept the principle of comprehensive medical treatment for everybody." They have accepted the principle. They are discussing with the doctors how this treatment should be organized. The doctors in Britain are, I am sure, completely prepared for a social insurance basis for medical treatment. While my report was being prepared the British Medical Association had a planning commission which made a report proposing that social insurance for medical treatment should apply to 90 per cent of the population; they wanted to keep an income limit of £420 a year, keeping 10 per cent out of insurance. When that proposal come before the British Medical Association as a whole, somebody moved an amendment to drop the income limit and apply insurance to 100 per cent. That amendment was carried by a small mojority. You may take it, the doctors in Britain are perfectly prepared for social insurance on health. As to the other point in question, the B.M.A. planning proposal was for the setting up of health centres for medical treatment so that doctors could work together in groups and give specialized treatment. Of course the doctors attach importance to free choice of doctors by patients and patients by doctors. It is quite possible under my scheme to have that, and I have no doubt we shall have that. There is also a difficult question as to how the hospitals should be organized. We have, as you know, a great system of voluntary hospitals and public hospitals; and there is a great deal of discussion as to whether the voluntary hospitals are to be preserved as voluntary hospitals or whether they should all be put under the local authorities. I should say, generally, that the doctors in Britain are prepared for a great development of social insurance in relation to treatment. I do not think they want to have a salaried medical service; but I am not sure how strongly they would oppose a salaried medical service if it were national rather than under the local authorities. There is nothing settled about that, and I cannot say exactly how it will be done.

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1943 Aug. 15 to Sept. 11	1943 July 18 to August 14	1942 August 13 to Sept. 9	1942 July 16 to August 12	TOTALS Jan. 1 to Sep. 11,'43	TOTALS Jan. 1 to Sept. 9,'42
Anterior Poliomyelitis	7	1	6	8	23	39
Chickenpox	15	42	24	51	1135	1532
Diphtheria	15	8	8	13	188	141
Diphtheria Carriers	1	....	1	1	18	8
Dysentery, Amoebic	1	....	....	....	7	....
Dysentery, Bacillary	1	2	2	1	10	8
Erysipelas	4	2	8	7	49	74
Encephalitis	2	....	8	11	6	29
Influenza	2	5	5	1	371	181
Measles	87	155	27	47	2519	4310
German Measles	....	4	....	1	142	262
Meningococcal Meningitis	....	4	2	3	26	21
Mumps	47	77	38	57	3130	2688
Opthalmia Neonatorum	....	....	....	....	....	1
Pneumonia—Lobar	2	5	1	4	132	85
Puerperal Fever	....	....	....	....	1	2
Scarlet Fever	45	43	21	45	1001	1081
Septic Sore Throat	2	2	1	....	33	59
Smallpox	....	....	....	....	....	....
Tetanus	....	....	2	....	1	3
Trachoma	....	....	1	....	2	5
Tuberculosis	49	33	59	44	443	405
Typhoid Fever	3	1	8	1	22	16
Typh. Para-Typhoid	....	....	....	....	3	2
Typhoid Carriers	1	....	....	....	2	1
Undulant Fever	1	1	....	2	7	8
Whooping Cough	72	78	48	50	1540	251
Gonorrhoea	127	121	121	137	1301	1011
Syphilis	34	32	54	75	373	519
Meningococcal Carriers	....	....	....	....	6	....

POLIOMYELITIS—Seven cases in Manitoba during this period but no more than the usual expectancy of sporadic cases. Minnesota also shows an increase over the last period.

DIPHTHERIA—Is by no means defeated. Have you any immunization clinics to start or finish this fall? We urge that you immunize as many children as you possibly can. Diphtheria still kills and has many complications.

TYPHOID FEVER—Should be kept in mind at this time of year. We have been fairly fortunate for some time but there are sporadic cases and no doubt *unknown* carriers.

GONORRHOEA—Is much too prevalent. Reporting of cases, sources and contacts, along with adequate treatment of cases can stamp out this disease. It requires a concerted effort.

DEATHS FROM COMMUNICABLE DISEASE

August, 1943

URBAN—Cancer 48, Tuberculosis 6, Syphilis 4, Pneumonia (other forms) 2, Diphtheria 1, Lethargic Encephalitis 1, Pneumonia, Lobar, 1, Whooping Cough 1, Mumps 1. Other deaths under 1 year 16. Other deaths over 1 year 162. Stillbirths 13. Total 256.

RURAL—Cancer 27, Tuberculosis 17, Pneumonia, Lobar 4, Pneumonia (other forms) 4, Syphilis 2, Lethargic Encephalitis 1, Cerebrospinal Meningitis 1. Other deaths under 1 year 21. Other deaths over 1 year 142. Stillbirths 16. Total 235.

INDIANS—Tuberculosis 6, Pneumonia (other forms) 2, Influenza 1, Puerperal Septicaemia 1, Dysentery 1. Other deaths under 1 year 7. Other deaths over 1 year 6. Stillbirths 2. Total 26.

DISEASE	Manitoba Aug. 15-Sep. 11 *737,935	Ontario Aug. 15-Sep. 11 *3,824,734	Saskatchewan Aug. 15-Sep. 11 *905,974	Minnesota Aug. 15-Sep. 11 *2,792,300	North Dakota Aug. 15-Sep. 11 *641,933
Anterior Poliomyelitis	7	7	3	49	4
Meningococcal Meningitis	....	7	1	3	3
Chickenpox	15	109	36	....	....
Diphtheria	16	5	1	19	8
Dysentery, Amoebic	1	....	....	8	....
Dysentery, Bacillary	1	....	2	1	....
Erysipelas	5	2	1	....	2
Influenza	2	56	1	2	20
Encephalitis	2	....	4	1	....
Measles	87	188	33	120	30
German Measles	....	24	6	....	....
Mumps	47	202	11	....	23
Scarlet Fever	45	117	43	64	8
Septic Sore Throat	2	3	1	....	....
Tetanus	....	....	1	....	....
Trachoma	....	....	....	....	†141
Tuberculosis	51	177	15	27	25
Tularemia	....	....	....	2	....
Typh. Para-Typhoid	....	5	....	....	5
Typhoid Fever	3	7	1	....	1
Undulant Fever	1	....	....	13	1
Whooping Cough	72	536	133	222	161
Diphtheria Carriers	1	....	....	....	....
Typhoid Carriers	1	....	....	....	....
Gonorrhoea	127	687	....	....	20
Syphilis	34	553	....	....	23

*Approximate Populations.

†Trachoma examinations performed by Dr. Loe at Turtle Mt. Agency.

Department of Health and Public Welfare

The Expectant Mother and Tuberculosis

by Ross Mitchell, M.D.

Clinical observers are agreed that pregnancy and tuberculosis, like alcohol and gasoline, form a bad combination. A woman with active tuberculosis who becomes pregnant has a double burden. If she is fortunate enough to be able to receive sanatorium treatment and to have the services of a competent obstetrician and internist, she may pass safely through the ordeal, but her less fortunate sister will hardly escape unscathed. Treatment of tuberculosis to be effective should be carried on throughout the whole of the gestation period, and this implies that tuberculosis, if not already known, should be diagnosed as early as possible in pregnancy.

The methods of diagnosing tuberculosis are the history as given by the patient, physical examination and X-ray examination. It is well recognized that dependence on the presence of symptoms and on abnormal physical findings is frequently quite inadequate for the detection of pulmonary tuberculosis. Many cases of tuberculosis reach an advanced stage before any symptoms are produced, and it is the exceptional case in which minimal lesions produce notable symptoms. The majority of patients in Manitoba sanatoria, and indeed in all sanatoria, are classified as far advanced on admission. Even experts in physical examination often fail to detect pulmonary tuberculosis. Sampson and Lawrason Brown carefully studied 1,004 patients with tuberculosis at the Trudeau Sanatorium in the Adirondacks. They found no physical signs of disease in 39.6 per cent of the patients and physical signs indicating less disease than the X-ray picture in an additional 36 per cent. It would thus seem to be evident that physical examination of the chest alone should be eliminated as a reliable tuberculosis case-finding method.

In the present world war X-ray examination of the chests of recruits for the armed forces has been almost universally adopted by the warring nations. In Canada the incidence of pulmonary tuberculosis discovered by this method in recruits has been approximately 1 per cent.

From 1934 onward fluoroscopy of the chest was introduced as a routine procedure for patients attending the pre-natal clinic of the Chicago Lying-in Hospital. Due to difficulties in inducing patients to make a special trip to the chest clinic for fluoroscopy, only 64 per cent of the clinic group were fluoroscoped during the first three years of the program. When the results of these three years were compiled, the incidence of 1.06 per cent of unsuspected clinically significant tuberculosis found by fluoroscopy seemed so important that efforts were made to extend the survey to all patients attending the pre-natal clinic. Since February, 1941, a fluoroscopy room staffed by members of the chest division has become an integral part of the pre-natal clinic, and all patients are fluoroscoped as a part of their initial examination. Those found to have definite or suspected lesions, in addition to those patients with known tuberculosis, or with tuberculosis discovered at the initial examination are referred directly for stereoscopic X-ray pictures. From 1937 to 1941, 10,968 pregnant women, unselected except for the exclusion of known tuberculosis, were fluoroscoped in the Chicago Lying-in Hospital and in this group 110 cases of unsuspected clinically important tuberculosis cases were discovered. This is an incidence of 1 per cent, which is similar to the incidence among army recruits.

It has been a universal experience that tuberculosis becomes more prevalent in time of war. It is rampant in France, and has increased in Great Britain and to a lesser extent in Canada. Moreover, tuberculosis is more likely to attack women in the early child-bearing years than at any other period. Though tuberculosis has declined from first to seventh place as a cause of death in the general population, it still remains the leading cause of death for women of the child-bearing age. The tuberculosis death rate in this age-sex group accounts for 20 per cent of all deaths, twice as high a mortality as from all puerperal causes.

Recent improvements in radiography, particularly the use of miniature film, have made it possible to reduce greatly the cost of X-ray examinations.

For all these reasons the Sanatorium Board of Manitoba recommends that expectant mothers should have an X-ray examination of the chest as early as possible in pregnancy. This examination may be either with the fluoroscope or with X-ray film. The recommendation is addressed particularly to pre-natal clinics in hospitals, which already possess X-ray equipment.

The Provincial Department of Health and Public Welfare for some years has urged that serological tests for the detection of syphilis be taken in all cases of pregnancy. This is a proper step but the incidence of syphilis is not so great as that of tuberculosis and its results are no more disastrous. Radiologic chest examination of expectant mothers should become a standard procedure in pre-natal care.